



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

VALLEY REGIONAL MEDICAL CENTER  
C/O HOLLOWAY & GUMBERT  
3701 KIRBY DR STE 1288  
HOUSTON TX 77098-3916

#### **Respondent Name**

COMMERCE & INDUSTRY INSURANCE COMPANY

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-08-0440-02

#### **MFDR Date Received**

August 10, 2007

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%. . . . the fees paid by AIG Claim Services, Inc. on behalf of Commerce & Industry do not conform to the reimbursement section of Rule 134.401. . . . Rule 134.401(c) (6) is entitled 'Stop-Loss Method'. The rule unambiguously states that, '**this methodology shall be used in place of and not in addition to the per diem based reimbursement system**'. . . . it is the position of Valley Regional Medical Center that all charges relating to the admission . . . are due and payable as provided for under Texas law and the Rules of the Division, as currently adopted and published at 28 TAC § 134.400, *et seq.*"

**Amount in Dispute:** \$20,673.85

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Requestor asserts it is entitled to reimbursement in the amount of \$184,501.29, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges. . . . There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. . . . Secondly, there is no evidence that the services provided by the hospital were unusually costly to the hospital. . . . Using the per diem method, this 14 day surgical admission qualifies for \$15652 (\$1,118 \* 14 days) in reimbursement. . . . Further, the Requestor is entitled to reimbursement for implantables (revenue codes 275, 276 and 278) and orthotics/prosthetics (revenue code 274) in a fair and reasonable amount. The carrier would suggest that the hospital's cost plus 10% would be fair and reasonable. . . . The Requestor may also be entitled to additional reimbursement for pharmaceuticals costing in excess of \$250 per dose. The Requestor must document the cost of such pharmaceuticals so Carrier may reimburse at cost plus 10%."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2006 to August 25, 2006	Inpatient Services	\$20,673.85	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 24 – Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
  - 42 – Charges exceed our fee schedule or maximum allowable amount.
  - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
  - W1 – Workers Compensation State Fee Schedule Adjustment

### **Findings**

1. The insurance carrier reduced or denied disputed services with reason code 24 – “Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.” Additionally, the requestor’s position statement asks that, in calculating the amount to be paid, an additional adjustment of “Less 10% (per First Health contract)” be applied. Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a managed care discount, capitation agreement, or contractual fee arrangement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5), which requires that “When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9).” Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 806.25. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection 134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor seeks reimbursement of \$20,673.85 based on “Total billable charges . . . Less SLRF Reduction of 25% . . . less 10% (per First Health contract).”
  - As stated above, review of the submitted information finds insufficient documentation to support that the disputed services are subject to a managed care discount, capitation agreement, or contractual fee arrangement between the parties to this dispute.

- The requestor did not discuss or support that applying the proposed methodology as found in the alleged contract would result in a fair and reasonable reimbursement for the services in dispute.
- The requestor further asserts that “the fees paid by AIG Claim Services, Inc. on behalf of Commerce & Industry do not conform to the reimbursement section of Rule 134.401 . . . Rule 134.401(c) (6) is entitled ‘Stop-Loss Method’. The rule unambiguously states that, ***‘this methodology shall be used in place of and not in addition to the per diem based reimbursement system’.***”
- Neither is the stop-loss methodology, as found in 28 Texas Administrative Code §134.401(c)(6), applicable to the services in dispute. As noted above, reimbursement for the disputed services is not calculated under the Division’s former *Acute Care Inpatient Hospital Fee Guideline* at §134.401; per §134.401(c)(5), when the ICD-9 code billed for these disputed services is listed as the principal diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Moreover, §134.401(c)(6) further states that “The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate.” The Division has found that the primary diagnosis is an ICD-9 code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to §134.1.
- The requestor did not demonstrate or provide documentation to support that applying the stop-loss methodology as found in §134.401(c)(6) would result in a fair and reasonable reimbursement for the services in dispute.
- The requestor did not demonstrate or provide documentation to support that total charges less a 25% and/or 10% discount would provide a fair and reasonable reimbursement for the services in dispute.
- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital’s billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of \$20,673.85 would be a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of this alternative amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement in the amount of \$20,673.85 is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute.

6. In the alternative, the requestor states that “it is the position of Valley Regional Medical Center that all charges relating to the admission . . . are due and payable as provided for under Texas law and the Rules of the Division, as currently adopted and published at 28 TAC § 134.400, ***et seq.***” Review of the submitted documentation finds that:
  - The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered . . . and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges . . .” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor did not submit documentation to support that payment of “all charges relating to the admission” would result in a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned

for services involving similar work and resource commitments to support the requested alternative reimbursement.

- The requestor did not support that payment of the requested alternative amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement based on "all charges relating to the admission" is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the alternative amount sought would be a fair and reasonable rate of reimbursement for the services in dispute.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

Grayson Richardson  
Medical Fee Dispute Resolution Officer

December 20, 2012  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**